

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008305

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1812

STATE FILE NUMBER

VS 300  
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN **St. Louis**

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION

**Deacones Hosp/**

Inside Limits  
Yes ☒ No ☐

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE **Missouri**

b. COUNTY

c. CITY OR TOWN **St. Louis**

Inside Limits  
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

**4109 Walsh**

Reside on Farm  
Yes ☐ No ☒

## 3. NAME OF DECEASED

First

**FRANCES**

Middle

**E**

Last

**BECKER**

4. DATE OF DEATH

Month **2-18-1963**

Day

Year

## 5. SEX

**Female**

## 6. COLOR OR RACE

**White**

## 7. Married

☐ Never Married ☐ Divorced ☒ Widowed

## 8. DATE OF BIRTH

**2-25-1918**

## 9. AGE (last birthday)

**44**

## 10. IF UNDER 1 YEAR

Months Days Hours Min.

## 11. IF UNDER 24 HR

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during year preceding death, or if retired)

**Receptionist**

## 10b. KIND OF BUSINESS OR INDUSTRY

**Medical Center**

## 11. BIRTHPLACE (City and state or country)

**Fort Smith Ark.**

## 12. CITIZEN OF WHAT COUNTRY

**USA**

## 13a. FATHER'S NAME

**Jess Goin**

## 13b. MOTHER'S MAIDEN NAME

**Julia Weeton**

## 14. NAME OF HUSBAND OR WIFE

**NONE**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give dates of service)

**NO**

## 16. SOCIAL SECURITY NO.

**NONE**

## 17. INFORMANT

**Judy Mc Graw**

## 18. ADDRESS

**4109 Walsh**

**16**

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

### IMMEDIATE CAUSE (a)

**Lymphangitic carcinoma lung**  
**Carcinoma of breast**

## INTERVAL BETWEEN ONSET AND DEATH

**6 weeks**  
**3 years**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

### DUE TO (b)

### DUE TO (c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

## PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

## 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

## 20a. ACCIDENT

☐

## SUICIDE

☐

## HOMICIDE

☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

## 20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

## 20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

## COUNTY

## STATE

## 21. I attended the deceased from

**Oct 1962**

**to 18 Feb 63**

and last saw her alive on **17 Feb 63**

## Death occurred at

**6 A.M.**

on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

**Joseph B. Cocco M.D.**

## (Degree or title)

## 22b. ADDRESS

**3915 Watson Rd.**

## 22c. DATE SIGNED

**18 Feb 63**

## 23a. BURIAL, CREMATION, OR DISPOSITION

**Burial**

## 23b. DATE

**2-20-1963**

## 23c. NAME OF CEMETERY OR CREMATORY

**S.S. Peter & Paul Cem**

## 23d. LOCATION (City, town, or county)

**St. Louis Mo.**

## (State)

## 24. FUNERAL DIRECTOR

**WINGBERMUEHLE 3819 SO Grand Blvd**

## ADDRESS

## 25. DATE RECD. BY LOCAL REG.

**FEB 19 1963**

## 26. REGISTRAR'S SIGNATURE

**Paul Smith. M.D.**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

Licensed Embalmer No. 4611

P. O. Address 187th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.